Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR SURGICAL HOSPITAL

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-14-2985-01

MFDR Date Received
May 29, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… This claim involved implants. We are requesting separate payment of the cost of implants plus 10% as indicated in these guidelines. The total cost of implants for this case was $30,799.15 Cost $30,799.15 X 10% = $$31,799.15 Expected implant reimbursement: $31,799.15."

Amount in Dispute: $1,507.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider was reimbursed per the provider specific rate for DRG 460. Implants were reimbursed at a cost + methodology. The provider is seeking separate implant reimbursement for a 'stapler" incorrectly billed under revenue code 278. A stapler is not considered an implant but rather a surgical supply The DRG base rate for this provider for DRG 460 is $22,668.86. This amount was multiplied by 108% to a DRG rate of $24,482.37. Please note that the calculation for the inpatient DRG rate excludes implant charges because implants are separately reimbursed. The adjusted billed charges used to determine the DRG rate was $82,124.94. It would be inappropriate to include charges in determining a DRG rate when implants are reimbursed separately."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 07, 2014 through February 10, 2014	Inpatient Hospital Surgical Services	$1,507.68	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- Z710 – The charge for this procedure exceeds the fee schedule allowance
- Z695 – The charges for this hospitalization have been reduced based on the fee schedule allowance
- X094 – Charges included in the facility fee
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
- Z710 – The charge for this procedure exceeds the fee schedule allowance
- P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).
2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   Review of the documentation finds that that the facility requested separate reimbursement for implantables; for that reason, the requirements of subsection (g) apply.

3. §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Review of the documentation found supports that the following items were certified as required by (g):

Itemized Statement Rev Code or Charge Code	Itemized Statement Description	Cost Invoice Description	# Units & Cost Per Unit	Cost Invoice Amount	***Per item*** Add-on (cost +10% or $1,000 whichever is less).
278	Implant Rod 70MM Prelord	70MM pre-lordosed rod	2 at $441.00 ea	$882.00	$970.20
278	Screw Bone Orthofix 6.5	6.5MMX45MM Modular bone	4 at $809.00 ea	$3,236.00	$3,559.60

		screw			
278	Screw Bone 7.5 X 40 MM	7.5MMX40MM Modular Bone screw	2 at $809.00 ea	$1,618.00	$1,779.80
278	Body Top Loading Orthofi	Body, Topy Loading	6 at $1,180.00 ea	$7,080.00	$7,788.00
278	Bone peek 28MM X 10MM X	TLIF Assy, 28mm x 10mm X 9mm	1 at $5,300.00 ea	$5,300.00	$5,830.00
278	Stapler Head Fixed 35 WI	No invoice found	$0.00	$0.00	$0.00
278	Screws Set	Set Screw	$226.00 ea	$1,356.00	$1,491.60
278	Gelfoam Size 100 (absorb)	No invoice found	$0.00	$0.00	$0.00
278	Sealant HMSTC FLSL BVN M	No invoice found	$0.00	$0.00	$0.00
278	Graft BN DBM 10ML Ptty	No invoice found	$0.00	$0.00	$0.00
278	Graft BN DBM 10ML Ptty	No invoice found	$0.00	$0.00	$0.00
278	Bone stimulator small	SPF-XL IIB 2/DM	$8,367.00	$8,367.00	$9,203.70

$27,839.00	$29,839.00
Total Supported Cost	**Sum of Per-Item Add-on**

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

4. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

   - Documentation found supports that the DRG assigned to the services in dispute is 460, and that the services were provided at Baylor Surgical Hospital. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $22,668.86. This amount multiplied by 108% results in an allowable of $24,482.37.
   - The total cost for implantables is $27,839.00. The sum of the per-billed-item add-ons exceeds the $2000 allowed by rule; for that reason, the total allowable amount for implantables is $27,839.00 plus $2,000, which equals 29,839.00.

   Therefore, the total allowable reimbursement for the services in dispute is $24,482.37 plus $29,839.00, which equals $54,321.37. The respondent issued payment in the amount of $54,886.37. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that no additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		10/17/14
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.